

State Illinois

## I. State Plan Definition of HMO

- (A) Is organized primarily for the purpose of providing health care services.
- (B) Make the services it provides to its Medicaid enrollees as accessible to them in terms of timeliness, amount, duration, and scope as those services are to nonenrolled Medicaid recipients within the area served by the HMO.
- (C) Makes provision, satisfactory to the Department, against the risk of insolvency, and assures that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent.
- (D) Is state certified as an HMO by the Illinois Department of Insurance, upon assurance that the HMO application meets the standards of the Illinois Department of Insurance and the Illinois Department of Public Health, in accordance with the Illinois Health Maintenance Organization Act (PA 78-1151).

10/1/96

## II. Prepaid Health Plans

- (A) Effective for services provided on or after October 1, 1996, the Department may arrange to provide Medicaid allowable services to persons eligible for Medical Assistance through an agreement with a prepaid health plan (PHP). Those arrangements shall be made through a contract, Interagency agreement, or intergovernmental agreement, as appropriate, between the PHP and the Department. The terms of that agreement shall be consistent with the requirements for non-risk PHPs found in 42 CFR part 434.
- (B) In order to be considered for a PHP agreement, the potential PHP must be one of the following:
  - (1) A health care provider that is an Illinois County with a population of over three million.
  - (2) An entity that is owned, operated, or governed by a State-funded medical school and will provide services only in areas that are outside counties with a population of over three million or any county adjacent to those counties.
  - (3) An entity that is a hospital, or group of hospitals, that can document, to the satisfaction of the Department, each of the following:
    - (a) Its ability to provide necessary care by having within the entity the health care resources necessary to provide at least 90 percent of all primary, secondary, and tertiary care that may be required by persons enrolled in its plan.

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- (b) Its critical role in the state's health care delivery system for the poor and indigent by having, within the entity, one or more hospitals that, during the State fiscal year immediately preceding the execution of the PHP agreement, qualified for critical hospital adjustment payments under this Plan.
- (c) Its historic and continuing commitment to serving persons eligible for Medicaid Assistance by, during three of the four State fiscal years immediately preceding execution of the agreement:
  - (i) If the entity is a hospital, that hospital must have either qualified for disproportionate share hospital adjustment payments or provided at least 25,000 days of inpatient care to persons eligible for Medicaid Assistance under this Plan.
  - (ii) If the entity is a group of hospitals, the entity must meet one of the following criteria:
    - (A) Each of the constituting hospitals must have qualified for disproportionate share hospital adjustment payments under this Plan.
    - (B) At least one-third of the constituting hospitals must have qualified for disproportionate share hospital adjustment payments and the constituting hospitals must have, on average, provided at least 10,000 days of inpatient care to persons eligible for Medical Assistance under this Plan.

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- (4) An entity that is a group of hospitals that can document, to the satisfaction of the Department, each of the following:
  - (a) Its ability to provide or arrange for all primary, secondary, and tertiary care that may be required by persons enrolled in its plan.
  - (b) At least one-half of the member hospitals must have qualified for disproportionate share hospital adjustment payments during two of the three State fiscal years immediately preceding execution of the agreement.

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- 07/97 (c) The constituting hospitals must, on average, during two of the three State fiscal years immediately preceding the execution of the agreement, have provided fewer than 10,000, and, in aggregate, no more than 50,000 days of inpatient care to persons eligible for Medical Assistance under the Illinois Medicaid State Plan.
- 07/97 (C) The services to be provided by a PHP shall be specified in the agreement between the PHP and the Department. Agreements must be signed no later than October 1, 1997.
- (D) The population that may be enrolled with and served by a PHP shall be specified in the agreement between the PHP and the Department but shall not be broader than the population that may be enrolled in the Illinois MediPlan Plus Demonstration, under the terms and conditions of that waiver. Enrollment in a plan offered by a PHP is voluntary, on the part of a person eligible for Medical Assistance. An enrollee may request disenrollment without cause at any time.

9/1/99

III Managed Care Community Networks

- (A) Effective for services provided on or after July 1, 1999, the Department may arrange to provide Medicaid allowable services to persons eligible for Medical Assistance through an agreement with a Managed Care Community Network (MCCN). Those arrangements shall be made through a contract between the MCCN and the Department. An MCCN may choose to contract with the Department to provide only pediatric health care services.
- (B) A Managed Care Community Network (MCCN) is defined as an entity, other than a health maintenance organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with the Department exclusively to persons participating in programs administered by the Department.
- (C) A MCCN must be a pre-paid, comprehensive risk-based plan which meets the requirements of Section 1903(m)(1)(A) of the Social Security Act.
- (D) A MCCN's organizational structure must meet the following criteria:
- (1) The MCCN shall be a separate entity organized as a corporation, limited liability company, or partnership under the laws of this State for the purpose of operating an MCCN and, except for a county MCCN, doing no business other than that of an MCCN.

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- (2) If organized as a stock corporation or limited liability company, 100 percent of all voting shares must be owned by, or 100 percent of all members in the limited liability company must be, providers of health care services who are subject to licensure by the Illinois Department of Professional Regulation, or who are subject to licensure or certification by the Illinois Department of Public Health or the Illinois Department of Human Services.
- (3) If organized as an Illinois not-for-profit corporation, the governing body must be constituted of at least 80 percent of providers of health care services who are subject to licensure by the Illinois Department of Professional Regulation, or who are subject to licensure or certification by the Illinois Department of Public Health or the Illinois Department of Human Services, or be employees or officers of such providers of health care services. For the purposes of this subsection, a State-owned medical school shall be a qualified provider of health care services.
- (4) If organized as a partnership, all limited and general partners must be providers of health care services who are subject to licensure by the Illinois Department of Professional Regulation, or who are subject to licensure or certification by the Illinois Department of Public Health or the Illinois Department of Human Services.
- (E) A County MCCN must be a county with a population of over 3 million that has a contract with the Department to provide primary, secondary or tertiary managed health care services as an MCCN and:
  - (1) May be formed without establishing a separate entity;
  - (2) Is entitled to enter into a contract to provide services in any or all of a county with a population of over three million; and
  - (3) Is not required to accept enrollees who do not reside within the county.
- (F) To be certified as an MCCN by the Department, an MCCN must meet each of the following requirements:
  - (1) An MCCN must execute a written contract with the Department.
  - (2) An MCCN must meet each of the requirements as set forth in Sections 1903(m) and 1932 of the Social Security Act and all other applicable federal and State statutes, regulations, rules, this Part and as defined in the contract.

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- (3) An MCCN must maintain procedures for enrollee complaints as established in contract with the Department. Such procedures shall, at a minimum, meet the standards set forth in the Health Maintenance Organization Act [215 ILCS 125] and applicable rules, applicable federal law, and as may be described in the contract.
- (G) The Department may limit the number of MCCNs with which it contracts and may specify a maximum and minimum enrollment capacity per MCCN. Any limitations would be in accordance with state and federal procurement rules.
- (H) The Department will include, in every contract with an MCCN, language describing the sanctions that the Department may impose upon the MCCN for failure to comply with the State Rules or the terms and conditions of that contract.
- (I) An MCCN must maintain a quality assurance and utilization review program. Such procedures shall, at a minimum meet the standards set forth in the Health Maintenance Organization Act [215 ILCS 125], applicable federal law and as may be described in the contract.
- (J) Each MCCN is required to adhere to minimum net worth requirements according to terms of the state Administrative Rules. Except during the first contract year, each MCCN must have and maintain at all times, a net worth of at least five (5) percent of the total annual capitated payments as calculated and based upon the MCCN's experience in its immediate prior fiscal year. However, the net worth of an MCCN need not be greater than \$1,500,000 during any contract year.
- (K) MCCNs are required to adhere to Solvency Standards according to terms of the state Administrative Rules and be licensed as a risk bearing entity. Each MCCN shall make adequate provision against the risks of insolvency. Solvency of the MCCN must be guaranteed by Guarantees or letters of credit from recognized financial institutions or by the establishment of escrow or trust accounts. Each MCCN shall assure that enrollees are in no case held liable for debts of the MCCN in the event of an MCCN's insolvency.
- (L) The services to be provided by a MCCN shall be specified in the agreement between the MCCN and the Department.
- (M) The rates to be paid to MCCNs shall be established by the Department.

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